STATEMENT OF
KRISTINE S. CHILDERS
ADJUTANT OF THE
DISABLED AMERICAN VETERANS DEPARTMENT OF NEBRASKA
BEFORE THE
CAPITAL ASSETS REALIGNMENT FOR ENHANCED SERVICES COMMISSION
OMAHA, NEBRASKA
SEPTEMBER 4, 2003

Mr. Chairman and Members of the Commission:

On behalf of the local members of the Disabled American Veterans (DAV) and its Auxiliary, we are pleased to express our views on the proposed Capital Assets Realignment for Enhanced Services (CARES) Market Plans for VISN 23.

Since its founding more than 80 years ago, the DAV has been dedicated to a single purpose: building better lives for America's disabled veterans and their families. Preservation of the integrity of the Department of Veterans Affairs (VA) health care system is of the utmost importance to the DAV and our members.

One of VA's primary missions is the provision of health care to our nation's sick and disabled veterans. VA's Veterans Health Administration (VHA) is the nation's largest direct provider of health care services with 4,800 significant buildings. The quality of VA care is equivalent to, or better than, care in any private or public health care system. VA provides specialized health care services—blind rehabilitation, spinal cord injury care, posttraumatic stress disorder treatment, and prosthetic services—that are unmatched in the private sector. Moreover, VHA has been cited as the nation's leader in tracking and minimizing medical errors.

As part of the CARES process, VA facilities are being evaluated to ensure VA delivers more care to more veterans in places where veterans need it most. DAV is looking to CARES to provide a framework for the VA health care system that can meet the needs of sick and disabled veterans now and into the future. On a national level, DAV firmly believes that realignment of capital assets is critical to the long-term health and viability of the entire VA system. We do not believe that restructuring is inherently detrimental to the VA health care system. However, we have been carefully monitoring the process and are dedicated to ensuring the needs of special disability groups are addressed and remain a priority throughout the CARES process. As CARES has moved forward, we have continually emphasized that all specialized disability programs and services for spinal cord injury, mental health, prosthetics, and blind rehabilitation should be maintained at current levels as required by law. Additionally, we will remain vigilant and press VA to focus on the most important element in the process, enhancement of services and timely delivery of high quality health care to our nation's sick and disabled veterans.

Furthermore, local DAV members are aware of the proposed CARES Market Plans and what the proposed changes would mean for the community and the surrounding area. A number of concerns and benefits have been expressed from Iowa, Minnesota, Nebraska, North Dakota, and South Dakota. Of particular concern in the restructuring of Capital Assets, is the meeting of

the goals VA has to meet the waiting time frames for primary and specialty clinic appointments. These goals have been expressed on numerous occasions and publications, however actual results of meeting this goal in the restructuring proposals, are not seen or identified within any of the VISN areas.

Multiple negative comments have been made, concerning communication between the VA personnel and members of the VISN 23 CARES CAMP teams which included members of the Veterans Service Organizations, individual veterans, concerned citizens, other identified and stakeholders. (Camp teams were used to describe the separate states and teams within those states participating in this CARES initiative). There was a lack of communication outside of the VA personnel within the CAMP Teams throughout VISN 23. VA personnel completed preparation of documents for presentation to the VISN 23 commission; however, some issues discussed in the planning process were not included in the final document. Specifically, the Iowa CAMP Teams received information that was not discussed in any meeting, OR recommendations made by members of the Iowa Camp Teams were not included in the document. In addition, uniform planning and review, system wide, were not present in determining the needs during the CARES process.

Concerns expressed:

- All areas of VISN 23 were given the broad stroke of interaction in the process with interested parties (Veterans, VSO's, Stakeholders, etc…). This is an inaccurate indication of participation, as all interested parties did not have opportunity to comment on the completed document prior to submission to the VISN Commission and VA Central Office CARES Committee.
- Users of the VA Medical System have repeatedly stated that they dislike the terminology, describing veterans as stakeholders, clients, etc… (The overwhelming desire by veterans is to be identified and called "veterans, patients, etc…).
- A recommendation was made to transform the Knoxville facility into a comparable relationship as is between the Minneapolis, MN to the St. Cloud facilities, with St. Cloud primarily as a psychiatric facility. There was an immediate response indicating this was infeasible due to cost and access and also that Minnesota would not be able to continue to operate as they are. Knoxville and Des Moines is similar in size and distance to each other as the Minneapolis and St. Cloud facilities are. Failure to disclose this option limited discussion and options to be considered by the Committee and Commission. (CARES report for Minnesota indicated a substantial savings for Minnesota. See Minnesota CARES report to VA Central Office).
- A Cost analysis is not indicated by a majority of the plans presented for review. The facts and figures for nearly all of the VISN's failed to provide how the changes recommended would financially impact the facility, as well as address the issue of access to meet the criteria as set out by the secretary for appointments. (Primary care, Specialty clinics). Users of the VA medical system are NOT convinced, by the presentations provided, that timely access will occur, and that ultimately there will be a dismantling of the medical system in some areas.
- One summary (Minnesota) clearly indicates the states financial inability to provide some services, which will have a negative impact in that state. Other states (Iowa-Knoxville)

have provided either no indication of a similar situation or that some negotiation is in process with the state to address possible uses of a given facility. This state however, does not have resources in which to provide the use being sought. (See Knoxville facility on land clearing and use as a Cemetery).

- Cost for demolition of buildings at the Knoxville facility versus savings associated with disconnection of services to unused buildings, was not provided in the CARES analysis recommendations.
- Construction of new facilities or renovation on the Des Moines campus resulted in needing to lease facilities off campus due to inadequate planning. (See domiciliary construction plan and results, VAMC Des Moines, IA).
- The placement of primary clinics off campus (Iowa City) is of such a concern that many veterans believe they will no longer be going to the VA for care. The thoughts expressed indicate that the VA is moving towards an HMO type setting and dismantling of the VA medical system.
- Sale of buildings/land/equipment/etc… was not discussed to ensure that proceeds would be retained by that facility/state in which they were sold.
- Funding considerations for the individual facility, given their unique demographic and geographic situations as a beginning point for measuring financial needs and changes have not been provided. A baseline of general operating need, followed by financial ramifications of change based upon CARES proposals is necessary. The assumptions made in proposals presented indicate a projected ability to handle an increase or change of caseload, without effect upon the funding needs for a given facility in nearly all proposals. Each facility must fully disclose the financial basis for proposals provided. Cost implications to changes as presented through the CARES process are not clear.
- Any efforts that are solely budget driven and that decrease services and limit access for veterans would be a mistake. Of primary concern is the need for the VA to focus on the most important element in the equation, quality health care and the greatest possible timely access to it by our nation's sick and disabled veterans. Any restructuring must ensure that specialized programs designed to meet unique health care needs are not adversely affected and that veterans served by a particular facility are not displaced from receiving necessary health care services.
- Centralizing locations has been noted as an inconvenience to users of the Nebraska VA medical facilities. VAMC Omaha has seen an increase in veterans' visits. Curtailing of services at Grand Island and Lincoln, NE, has resulted in longer waiting times, more complaints from users of the system, as well as added strain on employees. There is an apparent lack of consideration for appropriate staffing levels to meet increased patient load as well as the obvious increased cost or a cost savings by centralizing services.
- Many veterans in **South Dakota** are entitled to VA health care services. We have to make sure accessibility to health care improves. We are from a rural area and many veterans travel anywhere from 100 to 250 miles one-way for treatment. The CARES Commission should be aware of veterans programs and services that are good for veterans on the east coast (New York City) will not be effective or efficient for veterans in South Dakota.
- Forecasting future veteran populations with any accuracy is all but impossible for any timeframe beyond 2 or 3 years. Statistically, information used in planning for timeframes

such as used in the CARES plans are well beyond what will actually happen in 5, 10 or even 20 years down the road.

- South Dakota over 2,000 troops were called to active duty since January 1, 2003, not to mention those called up elsewhere within VISN 23. One thing we can be sure of is that veterans are not going away. We feel as long as a single veteran is alive, we have an obligation – a sacred duty – to see to it he/she receives adequate and compassionate health care.
- There is a concern that the CARES Market Plans, which constitutes significant reorganization, will give way to a redefinition of veterans health care within the VISN and throughout the entire VA Healthcare system.
- The Hot Springs VA Medical Center serves rural veterans of Nebraska, South Dakota, and Wyoming. These rural veterans depend on and are well satisfied with the health care at the Hot Springs VAMC. Plus the VAMC provides care for the 120 to 150 residents at the Michael J. Fitzmaurice South Dakota State Veterans Home and the 60 veterans at the VA Domiciliary. We question how this will affect health care to our veterans, as proposed, Hot Springs VAMC is made an 8-hour operational clinic versus a 24-hour hospital facility.
- Market share for each area within the VISN and nationally, is noted as a percentage of the veteran population within an area that are enrolled within that area (See August 4, 2003 National Summary). The percentage of veterans used in reports must be consistent and pertinent to needs of a given area. As previously noted, a facility such as South Dakota has 9 percent of the total enrollees for VISN 23, yet the South Dakota facility has a minimum financial need for operations, as well as space to meet the needs of veterans served, that must be considered. Ironically, the Western Wisconsin veteran population is the largest group of users listed in VISN 23. Western Wisconsin users are split in usage to multiple facilities. Furthermore, statistics are not fully explained in their importance to decision making for construction, funding, use of given facilities, etc… Percentages reported under market share do not provide value or pertinence to the recommendations made for the needs of VISN 23.

Positive comments:

- Comprehensive analysis of the Minneapolis/St. Cloud facility use to provide the best possible cost savings and work load between the centers. Options were clear and provided logical decision-making.
- Reorganization of space at VAMC Minneapolis for optimum use is noted as a positive solution for access at this facility.
- Construction of an up to date Long Term Care (LTC) facility on the Des Moines grounds provides all services needed at one facility for these unique patients and is cost productive. Renovation of Knoxville LTC facility will cost approximately the same, but combines services with Des Moines is seen as the appropriate action to be taken. It provides a facility that will be up to date and a life span consistent with the needs of veterans and financial responsibility.
- Co-location opportunities at Des Moines and Minneapolis locations are noted. Cost savings are not provided in the CARES documents; however, other known documentation indicates a substantial savings for VA as well as increased access by

veterans to the Veterans Benefits Administration Regional Office in Des Moines, Iowa, which is consistent with the VA's goal of "One VA". (No information is noted for co-location in Minneapolis). Use of existing facility is at Fort Snelling should continue. Claimants have ease of access to VBA and multiple other agencies as needed.

- We support the establishment of new Community Based Outpatient Clinics (CBOC's) in Iowa; South Dakota; North Dakota; Nebraska and Minnesota.
  (Spirit Lake, Shenandoah [share with NE], Cedar Rapids, Marshalltown, Carroll, and Ottumwa). (Wagner, Watertown). (Grand Forks AFB, Devils La ke, Williston, Dickinson [share with S.D.] and Jamestown). (Holdrege, O'Neill, Bellevue [DoD], and Shenandoah [share with Iowa]). (Bemidji). Are sites identified in the Market area summaries.

As the leader of the Veterans Administration, General Omar Bradley stated very well the responsibility of the VA: Were dealing with their problems (veterans), not ours. The Veterans Health Administration must be looked at in a manner that will provide the needed care of those who have already "borne the battle". Even as many pass on daily to our Private, State and National Cemeteries, new veterans are coming into the system daily. As long as there is a military, there will be veterans who need the care that the VA must provide. VA must have a positive, realistic, viable solution for the needs of veterans' care in each and every state of the union. A clear and concise plan must be in place to ensure all the VISN's, all the VA Medical Centers, are on the same page of providing care as mandated by congress. Clear direction from VA Central office must be communicated to each facility and reviewed consistently to ensure compliance with the mission and goal of the Department of Veterans Affairs as well as the mandates of Congress.

In closing, the local DAV members of VISN 23 sincerely appreciate the CARES Commission for holding this hearing and for its interest in our concerns. We deeply value the advocacy of this Commission on behalf of America's service-connected disabled veterans and their families. Thank you for the opportunity to present our views on these important proposals.

STATEMENT OF
TOM MULLON
THE AMERICAN LEGION
BEORE THE
CAPITAL ASSET REALIGNMENT FOR ENHANCED SERVICES
(CARES) COMMISSION
ON
THE NATIONAL CARES PLAN

SEPTEMBER 4, 2003

Mr. Chairman and Members of the Commission:

Thank you for the opportunity today to express the local views of The American Legion on the Department of Veterans Affairs' (VA)'s Capital Asset Realignment for Enhanced Services (CARES) initiative as it concerns Veterans Integrated Services Network (VISN) 23. As a veteran and stakeholder, I am honored to be here today.

The CARES Process

The VA health care system was designed and built at a time when inpatient care was the primary focus and long inpatient stays were common. New methods of medical treatment and the shifting of the veteran population geographically meant that VA's medical system was not providing care as efficiently as possible, and medical services were not always easily accessible for many veterans. About 10 years ago, VA began to shift from the traditional hospital based system to a more outpatient-based system of care. With that shift occurring over the years, VA's infrastructure utilization and maintenance was not keeping pace. Subsequently, a 1999 Government Accounting Office (GAO) report found that VA spent approximately $1 million a day on underused or vacant space. GAO recommended, and VA agreed, that these funds could be better spent on improving the delivery of services and treating more veterans in more locations.

In response to the GAO report, VA developed a process to address changes in both the population of veterans and their medical needs and decide the best way to meet those needs. CARES was initiated in October 2000. The pilot program was completed in VISN 12 in June 2001 with the remaining 20 VISN assessments being accomplished in Phase II.

The timeline for Phase II has always been compressed, not allowing sufficient time for the VISNs and the National CARES Planning Office (NCPO) to develop, analyze and recommend sound Market Plan options and planning initiatives on the scale required by the magnitude of the CARES initiative. Initially, the expectation was to have the VISNs submit completed market plans and initiatives by November, 2002, leaving only five months to conduct a comprehensive assessment of all remaining VISNs and develop recommendations. In reality, the Market Plans were submitted in April 2003. Even with the adjustment in the timeline by four months, the Undersecretary for Health found it necessary in June 2003, to send back the plans of several VISNs in order for them to reassess and develop alternate strategies to further consolidate and compress health care services.

The CARES process was designed to take a comprehensive look at veterans' health care needs and services. However, because of problems with the model in projecting long-term care and mental health care needs into the future, specifically 2012 and 2022, these very important health care services were omitted from the CARES planning. The American Legion has been assured that these services will be addressed in the next "phase" of CARES. However, that does not negate the fact that a comprehensive look cannot possibly be accomplished when you are missing two very important pieces of the process.

The American Legion is aware of the fact that the CARES process will not just end, rather, it is expected to continue into the future with periodic checks and balances to ensure plans are evaluated as needed and changes are incorporated to maintain balance and fairness throughout the health care system. Once the final recommendations have been approved, the implementation and integration of those recommendations will occur.

Some of the issues that warrant The American Legion's concern and those that we plan to follow closely include:

? Prioritization of the hundreds of construction projects proposed in the Market Plans. Currently, no plan has been developed to accomplish this very important task.
? Adequate funding for the implementation of the CARES recommendations.
? Follow-up on progress to fairly evaluate demand for services in 2012 and 2022 regarding long-term care, mental health, and domiciliary care.

VISN 23- NEBRASKA AND IOWA

Iowa

To address the Primary Care Access problem in Iowa, the Draft National CARES Plan (DNP) proposes to establish four new Community Based Outpatient Clinics (CBOCs) throughout the market. The American Legion believes this is a positive step, however, ensuring VA personnel staff these CBOCs is very important. Veterans seek care at a VA facility because they feel comfortable with the environment. Studies have shown that veterans will forgo a community medical facility, even if it is an emergency, to get to a VA facility further away, just so they can receive their care there.

The DNP proposes to increase hospital care access in Iowa by proposing to contract care through the community. The American Legion believes that excessive contracting will lead to vouchering and privatization and eventually to the dismantling of the VA system. We believe VA should exhaust all avenues of providing care to veterans before they look to the community to fulfill the need. Vendors may not understand or have interest in the culture and mission of the VA, resulting in a different or lower standard of service quality. There are many other reasons why contacting out VA services may not prove beneficial to the VA or the veteran such as: loss of in-house expertise; future cost increases when the VA has discontinued the service; and most important for the veteran, the loss of continuity because of the transition between contactors. While we understand it is necessary in some cases, every effort should be made to avoid it.

The Knoxville facility is to maintain outpatient services but transfer all inpatient services including acute care, long-term care and domiciliary to Des Moines. The American Legion believes this will cause a tremendous hardship on the veterans in the Knoxville area. Now, instead of VA care, they will be contracted in the community or have to drive to Des Moines to get their care.

Also, in the Knoxville situation, the plan calls for the elimination of the 228-bed VA nursing home beds and the building of a 120-bed nursing home at Des Moines. At a time when the need for long-term care beds is growing due to the aging of our veterans, why are we planning for a reduction of nursing home beds?

In addition, The American Legion would like to remind the Commission, that inaccurate numbers were reported for VA outpatient mental health, long-term and domiciliary care in the original CARES model. As a result, a decision was made early on to omit these numbers from the first phase of CARES. How can you move the domiciliary beds and long-term care when the projections are admittedly inaccurate?

Nebraska

The American Legion does not oppose the proposals for the Nebraska market concerning the renovations and expansion planned for the Omaha Medical Center. We also support the opening of four additional CBOC's in Nebraska. We do, however, disagree with the VA's listing of the four new CBOC's in the Nebraska market in Priority Group 2. The VA's Driving Time Guidelines for access to primary care are not currently being met in the Nebraska market and, even after adding these four additional CBOC's the goal of 70% will not be met. The American Legion believes that the four clinics should be planned in Priority Group 1.

There is also a proposal for collocation with the Veterans Benefits Administration (VBA) on the Lincoln campus. However, this collocation is only a medium priority in the DNP. The American Legion is unaware of what exactly "medium priority" means and why such a collocation is not a higher priority. .

The American Legion understands that the CARES process encourages flexibility and recognizes that future planning of any organization as large as the VA will be subject to many modifications as the process evolves. We do, however, have concerns that decisions made now based on incomplete data and driven by funding considerations and not based on veteran's needs may be regretted in the future. We will be watching the implementation phase of CARES very carefully.

Thank you for the opportunity to appear before you today. I will be happy to answer any questions.

Iowa Commission of Veterans Affairs
7700 NW Beaver Drive
Camp Dodge
Johnston, Iowa 50131-1902

Department of Veterans Affairs
Cares Commission
Washington DC

Cares Commission,

I am not at all optimistic about the future results of CARES. I know the VA has been restructured before and we continue to have problems.

If the whole reason behind CARES is to try to better serve our nations veterans for less money where possible. Will that money that is saved be used to give better or expanded care to our veterans in addition to what is already being spent or will it be used in some other manner?

Veterans have been short changed for health care funding for many years and hopefully that will change, especially with our situation with our troops in harms way on a daily basis. I am opposed to closing any medical facility which would affect the availability of care a veteran has access to for that region. I feel more CBOC's located throughout the State of Iowa would better serve our aging veteran population with more accessibility. I also realize that even with CBOC's in the locations being considered we will still have areas in North East Iowa and Southern Minnesota that will not be adequately be serviced by our own VISN. At

present it is my understanding there are approximately 711 Iowa veterans and 829 Minnesota veterans who get their care in VISN 12. Serious consideration needs to be given to North East Iowa as a CBOC location too.

I also request serious consideration will be given to the use of some of the vacant land at the Knoxville for a state veterans cemetery.

Hopefully all testimony and considerations will be evaluated objectively for both favorable and/or non-favorable results.

Sincerely,

Patrick J. Palmersheim
Executive Director
Iowa Commission of Veterans Affairs

VISN 23 CARES UP DATE

Alfonso G. Martinez Jr.
Disabled American Veterans
Fremont Chapter No. 18, Adjutant
Legislative Assistant, Service Officer
Department State of Nebraska

September 9, 2003

Department of Veterans Affairs
CARES Comission
Capital Asset Realingment for Enhanced Services

Attention:
Vice Chairman R. John Vogel, Hearing Chair
Commissioner Vernice Ferguson
Commissioner Dr. John Kendall
Commissioner Robert Ray

Regarding : Date, September 4, 2003,
Location : Holiday Inn Central, 3321 S. 72nd Street, Palace G,
Time: 1:00p.m. - 5:00p.m.

Topic: Review of the Draft National CARES Plan for VISN 23

I will start by submitting my information regarding VISN 23 in a chronogical manner. It is important that all parties concerned, which are the following: Veterans Integrated Service Network(VISN) 23, Department of Veterans Affairs CARES Commission, Executive Leadership Council (ELC), Management Assistance Council (MAC), regarding the materrs of Capital Assets Realignment for Enhanced Services (CARES) and the Issues of Steering Committee; 9-step Process and Timeline; Communication Plan; Proposed Market Areas; Infrastructure Assestment and Community Based Outpatient Clinic (CBOC).

On May 13, 2002 an Oversight Hearing on the Integration of Veterans Integrated Service Networks 13 and 14 was held. At which time I was a Witness on one of the Panels presenting testimony at that hearing. (See Attatchment A). Regarding this I will only repeat and say the one concern I had that day otherwise please see the attatchment. I Pray we have not been merged to be obsorbed and later disolved.

VISN 23 CARES UP DATE

Later on July the 22, 2002 at a MAC Meeting we were told the following:

From 1990 to 2000 the V.A. changed delivery of Health Care shifting from a Hospital-Based System to an Integrated System focused on Prevention, Early Detection of Desease, the Promotion of Better Health Care and Easier Access to Care. Basis for shift/change, previous primary focus was long admissions inpatient care. Geographic Concentrations of Veterans changed and new methods of medical treatment changed. V.A. System not providing care as efficiently as possible. Medical Services were not easily accessible to some Veterans. System redesigned to treat More Veterans in closer Community -Based Clinics. It was quoted by the minutes that the Majority of Care is provided in outpatient clinics. As of (May of 2002), more than 800 Ambulatory and Community-Based Outpatient Clinics provide this care. In the mean time a (GAO) General Accounting Office Report c/o the V.A. states that , V.A. spends 1 of every 4 dollars on Maintaining Buildings ." Funds could be better used treating more veterans in more locations" V.A.'s process to address projected changes in veteran population, medical needs and best way to meet those needs is still not clear to me as to how. Once V.A.'s CARES Process is Quote completed, "V.A. will be able to provide accessible care to more veterans.

Based on the V.A. report that the majority of care is being provided by Ambulatory and Community-Based Outpatient Clinics, why are patients from those areas still being transported or transport themselves to the Main VAMC c/o Specialty Clinics and other services provided only by a V.A. Facility. If according to the GAO Report 1 in 4 dollars is spent to maintain VAMC Buildings, why were Lincoln and Grand Island VAMC's closed/ or reduced in services and still transport patients to main VAMC in Omaha. The overflow is overwhelming to Omaha how are we saving and providing more accessible care and serving more veterans with a larger waiting list and doing away with priority 8 level of patients. Community-based Outpatient Clinics are in fact a positve step and O Neill and Holdrege Nebraska are in great need as they have the need and numbers for our area. And as services are made readily available and accessible our numbers will continue to increase of Veterans using the V.A.M.C.'s System. At what point will overflow to the Omaha VAMC and the lack of use c/o the Lincoln and Grand Island VAMC's serve to the fullest measure or potential. Keeping in mind that the shift for short term and immediate emergency care is the main focus. that is to say if all V.A. Health Care Issues can be addressed a a local level through Community-Based Outpatient Clinics without concern of overflow and specility clinics, fine, but, this is not the case for two(2) main reasons. (1) One, WWII, Korean, Vietnam Veterans more and more are

unfortunately becoming long term and serious care patients. In (10) ten years Persian Gulf War Veterans will have been 20 years out and older veterans. This does not include Graneda, Panama, Lebanon, Somalia, Bosnia, Korea, Iraq and more and more Police Action Peace Keeping Missions in areas throughout the world and around the globe our Veterans Men and Women continue to answer the call to Duty for God and Country and their Families.

Remember just a few years back we as Veterans were told that there were 25 mil. Eligible Veterans that could the V.A.System and only 5 million were using the V.A. Because of the increase in the use of the V.A. Health Care System, as the increase^ in numbers has contiued to show for the past few years, there will be an overflow and there will be an increase of specialty clinics need. Simply put you currently have the largest number of Veterans in the History of this Nation who have the need and accessiblity to use the V.A. based on their medical and mental health care problems and needs.

Given this information please continue the expantion of Community-Based Outpatient Clinics, but do not stop maintaining the VAMC's needed to provide care for the overflow and specialty clinics. Why then are Nebraska's CBOC's a priority 2 instead of 1. A last minute attempt on the part of the VISN Leadership to make final changes regarding Nebraska CBOC Priority From a 2 to a 1 was not presented well. While on the other hand Minnesota, Iowa and even the Dakota's were well represented. The VISN and Nebraska Leadership did not provide the COMMISSION WITH COMPLETE AND WELL THOUGHT OUT INFORMATION/DATA. The areas of Budget and Finance are especially important since a contiued track record of finacial short falls has plagued both VISN's in past years. The Commislon can not act upon good intentions and we will get back to you later on that information. Questions were addressed by the Commission and the VISN 23 Panel did not respond with complete, acurate and well thought out data.

Since then the Veteran Advocacy has encourage a greater awareness of the roll of VERA to the VISN. An example is the Classification of patients at the time 44 and the reimberment process of each patient. The V.A. Support Structure at the national Budget Level. Finally the Third Party Program regarding the collections Third Party Health Care Insurance and Medicare Cost Recovery(MCCF) Program. Reports being presented in a timely manner /on time, and with out short falls in the collection of monies and identification of patient reimbursement If not done properly each year has a devistating affect on the ability of operating revenue for the VISN. Never the less we Pray that the National Office of the V. A. will not penalize or jeperdize the greatest need of Health Care to more than 3

Generations of Veterans of this Great Nation. Especially since CARES is based on the careful Analization of Data from Multiple Sources and Applying Criteria and Actual Projections. Especially since the Final decision is based on the Approval of this Commission and Secretary of the V.A. as discribed in the CARES Process.

Provided that the Stake Holders Communication of their needs were adiquately provided with sufficient information to assist the ELC with the proper feedback needed to aid and assist the commission is not clear. My main concern is that our Stake Holders and ELC should agree on what the needs of Nebraska are. In fact the Iowa delegation was so well represented by the American Legion, a former V.A. Official well versed in the process and very well aquainted with the V.A/ VISN Personnel, God Bless and good for you. I was very Proud of Knoxville, Iowa's participation and presentation. Although smaller in comparison to a larger metropolitan area, they filled the hearing room with a voice that was well heard and well represented. As did the Dakota's c/o of the Veterans of Foreign Wars Advocacy. A comment was made on behalf of Nebraska which was in effect, the following: Even though Population-wise our numbers do not compare to other larger populated states, Every Veteran is Eligible and Intitled to the best quality health care possible regardless of the size of their state or Veteran population.

VISN 23 report dated July 24,2003 stated the following:

Regarding Transitional Pharmacy Benefit we receive hundreds of new applications each month. Most significant waits are at the Minneapolis VAMC. Nebraska, Sioux Falls, and St. Cloud are mentioned but no numbers as to waiting list are stated. This year facilities with the greatest need were given additional resources to support initiatives for eliminating waits list. Details, a list or basic data as to how many and where was not provided. Please see attatchment C.

Regarding Non-VA Physicians to fill VA Prescriptions, there is a great concern on cost factors upon individual request of medications and liability in what is fair for one patient versus another. Is this a good move? VA estimates 200,000 Veterans will be eligible for this benefit.

Recently a new VA Director of the Nebraska-Iowa Health Care System(HCS) was appointed Mr. Albert Washko. With such a great concern for operating costs c/o VISN 23 it should be noted that from the time of the Integration of VISNs 13 and 14 to VISN 23 the Nebraska-Iowa Health Care System has gone through several Directors and Acting Directors. This has been very stressful, confusing, and hard

in maintaining a stable and solid Administration. Each time a new person filled the position whether as Director or Acting Director accountability for short falls and set backs due to change was a difficult task to address and not fair to the in coming or out going Director and Administration especially with existing problems not completely resolved due to reduction in monies, less employees, with an increase in the number of patients being treated.

There is and continues to be a need and concern for updated and current hospital equipment, surgical facility areas, and specialty clinic needs. These needs should not be compromised by budget and financial short falls. Monies envolving building maintenance should be used wisely. The relocation of administrative offices and clinics should not have to be that often. Example the Directors Office was moved 3 times with in a 15 month period. Changing the terminology of clinics from north, south, east, west and middle to yellow, gold red green blue etc. is confusing to the patient, requires time, cost in rearranging, how does this help provide a better service. Hopefully this not realinement of a medical facility. The utilization of funds between departments if available and not being used in a specific area should be accessible to a needed area if the money is not being used. Example in the past monies were appropriated for Building Maintenanceand not used over long period of time and now those monies are subject to the general fund because that building is no longer being used.

The Commission on more than one instance asked the VISN Director Dr. Robert (Randy) Petzel questions regarding the cost of facilities such as Lincoln and Grand Island VAMC's as far as maintaining, developing, analysis needs, planning initiatives, development of market plan, proposed market areas, infrastructure assestment for the purpose of future evaluation as to what to do with these buildings as well as other buildings throughout VISN 23. Sufficient Data was not provided to the Commission. How can this help Nebraska/VISN 23 regarding the issue of future development and realinement and proposed market areas.

A greater need for Long Term Hospital Care and Nursing Homes are and will continue to be a greater need with increased numbers of aging Veterans. Steps to address this issue are moving very slow. As it is decisions made now it seems will not take effect until 2015 or even 2020. What is to happen in the mean time. With the increase in Primary Care, Hospital Care, Surgical Proceedure, Mental Health Care, Pharmacy Care, and Specialty Care. Currently there is a stressfull demand on all VAMC's, Ambulatory Care and CBOC's. Will Lincoln or Grand Island be used for more examination rooms or a nursing care facility in order to convert and redristribute areas of service. the Omaha VAMC

already has a 38% increase in outpatient and specialty care and will continue to have an increase due to the over flow of patients. It is true that UNO Medical Center and Creighton Medical Center are more than eager to assit with this matter, but a strictor compliance and accountability of contractual agreements between the VA and Private Medical Centers should be implemented regarding liabilities and loyalties of patient service to be readily available on a 24 hour 7 day a week basis regardless of patient load and not only by Interns but specifically by the MD's/ Doctors/ heads of Staff. it should never be a case of who comes first in the sense of VAMC versus Medical Centers sufficient staff and time should provided at all times. Please also note attachments D, E, and F c/o Statement of the Honorable Anthony J. Principi secretary of Veterans Affairs, VA CARES Planning for Veterans Future Needs by Leo S. Mackay, Jr. Ph.D., Deputy Secretary, Department of Veterans Affairs, and Veterans Updates from July 24th through Septmeber 5, 2003.

It was also noted that $142 million from Congress attached to a Defense Supplimental for fiscal year 2003 as of June 2002 regarding the completion of Phase I Financial Feasability and Awareness. Bringing to mind that Phase II now includes the Integration of VISN's 13 and 14 which now makes VISN 23 the second largest VISN in the Country. Two VISNs that were not very successfull at the time of Integration. How sucessful are they now ? Will Minnesota beacause of size and numbers continue to take priority, along with Iowa and will the Dokota's and Nebraska take a back seat for lack of a better word to this philosophy. Please do not sugar coat what in the end means the Future of Nebraskas Veterans and surrounding smaller areas of our VISN's well being because of size, numbers and priority. I did not take kindly to the remark of comparison of Human Life per square mile and that of cattle per square, a remark made by a panel member not the commission. This is a serious matter and should not be taken lightly. The decisions made now will affect the Future and well being of our Veterans in Nebraska and the VISN. I was very pleased to see Representatives from the Office of Senator Benjiman E. Nelson, Deputy Legislative Assistant Megan McCurdy. Please see attatchment B regarding the statement submitted by his office to the Commission regarding the hearing. I would encourage and even challenge VISN 23 and the ELC, as well as our Senators and Congressmen and Veteran Advocacy of Nebraska to Rally together in a United effort to continue and maintain the best quality Health Care for All our Veterans here In Nebraska and throughout VISN 23 now and in the future. The History regarding the use of the VA System has always been one of numbers. Veterans are told if they don't use it they will loose it. When numbers increase then veterans are told that buget costs restrict cerntain priority groups, therefore waiting lists are established. It is important not to discourage,

send away or refuse Veterans service because the budget is affected by it c/o loss of operating revenues based on the number of Veterans treated. This is a vicious cycle that must stop in order to preserve and maintain a consistant quality Health Care Service for Veterans.

Respectfully,

Alfonso G. Martinez Jr., Disabled American Veterans
Nebraska State Service Officer &
Legislative Assistant State of Nebraska